JOSEPH BRANT HOSPITAL

COLONOSCOPY REFERRAL FORM

Please fax referral form and other documents to: (905) 681-4961

Patient Information (or affix sticker)

Name: _____ Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Alt. Phone: _____

DOB (D/M/Y): _____ Gender: _____

HCN: _____ Family Physician: _____

REFERRING PROVIDER INFORMATION

Name: _____ Billing Number: _____

Phone: _____ Fax: _____

Date of Referral (D/M/Y): _____ Signature: _____

INDICATION FOR REFERRAL

- ☐ Average Risk Screening
- ☐ 1st Degree Relative with Colon Cancer
- ☐ Personal History of Colon Adenoma(s)
- ☐ Symptoms (e.g. rectal bleeding, change in bowel habits): _____

PATIENT HISTORY

1. Has patient had a prior colonoscopy ○ N ○ Y (attach a copy of most recent reports with this referral)
2. Does patient have a history of colon polyps ○ N ○ Y (attach a copy of most recent reports with this referral)
3. Does patient take any of the following agents

☐ ASA	☐ Pradaxa (Dabigatran)	☐ Plavix (Clopidogrel)	☐ Xarelto (Rivaroxaban)
☐ Coumadin (Warfarin)	☐ Eloquis (Apixaban)	☐ Brilinta (Ticagrelor)	

4. Does patient have the following medical conditions

Coronary artery disease with unstable angina or a recent MI (within the past 12 months)?	○ Y	○ N
Congestive heart failure?	○ Y	○ N
Implanted cardiac pacemaker and/or defibrilator (ICD)?	○ Y	○ N
Diabetes on insulin?	○ Y	○ N
Chronic renal failure (eGFR <60 ml/min)?	○ Y	○ N
Significant respiratory disease (COPD, sleep apnea, restrictive lung disease)?	○ Y	○ N
History of adverse reaction to sedation or anaesthesia?	○ Y	○ N
Substance/alcohol use disorder and/or chronic high dose opioid or benzodiazepine utilization?	○ Y	○ N
Coagulopathy or platelets < 50?	○ Y	○ N

Thank you for the referral. JBH will contact your office to confirm receipt of referral and will contact your patient with relevant appointment dates and times.